H&R BLOCK

Return the completed form to:
Benefits Department
H&R Block
4400 Blue Parkway
Kansas City, MO 64130

EXHIBIT
15
McCray
MG 6/8/05

REQUEST FOR LEAVE OF ABSENCE

Instructions: Sections 1, 2, 3 and 4 are to be completed by the associate. Check all applicable boxes and sign and date Section 6. Return the completed form to the supervisor. The supervisor signs and completes Section 6 and returns the form to the H&R Block Benefits Department at the address above.

Section 1

Associate's Name: Adrian McCray Social Security Number: 031-54-3895

Job Title: Field HR Manager Corporation:

Department: Division 50

Is your spouse employed by H&R Block corporation? ☐ Yes ☐ No ☐ Not applicable

If yes, spouse's name and corporation where employed?

Last Day Worked: January 6, 2003

I request leave: From 1/6/03 to undetermined 1/22/03

Is this request: ☑ Yes ☐ No If no, is this a request for extension or additional time off: ☐ Yes ☐ No

Section 2

Identify the reason for the leave (check the applicable box):

✖ Medical (self) ☐ Family Related ☐ Maternity ☐ Military ☐ Personal

Section 3

The requested leave is for (check any applicable boxes):

☐ The birth of a child and/or care for a child within the 12-month period following birth.

☐ The adoption or foster care placement of a child and/or to care for a child within the 12-month period following adoption or placement.

☐ To care for my ☐ spouse, ☐ son, ☐ daughter or ☐ parent with a serious health condition. I understand that a completed *"Certification of Health Care Provider"* form is required.

☒ Because of a serious health condition (non-job related) that prevents me from performing the functions of my job. I understand that a completed *"Certification of Health Care Provider"* form is required.

☐ Because of a serious health condition due to occupation. I understand that a completed *"Certification of Health Care Provider"* form and an *"Employee Accident, Injury or Illness Report"*, Form 2414 are required.

☐ Other - Please explain:

JAN 10 2003

NS B 197

tion 4

quest that my leave be taken:

nsecutively (consecutive leave is taken successively in an uninterrupted order)

On an intermittent basis as follows: (Intermittent leave means that the entire leave is not taken consecutively but is taken in smaller increments such as days or weeks.)

On a reduced work schedule basis as follows: (Reduced leave means a reduction in the usual number of hours worked per work week or work day.)

ection 5

n employee is eligible for leave under the **FAMILY AND MEDICAL LEAVE ACT (FMLA)** if the employee has been mployed by the employer for at least twelve months and the employee has been employed for at least 1,250 hours uring the immediately preceding twelve month period. An eligible associate who is approved for FMLA based on edical certification may take up to a total of twelve (12) work weeks of unpaid FMLA leave during a twelve (12) month eriod (or longer if required by applicable state or local law). The twelve (12) month period is determined using a rolling welve (12) month period measured backward from the date the associate begins using any FMLA leave.

eligible, you have a right under the FMLA for up to 12 weeks of unpaid leave in a 12-month period for the reasons sted above in Section 3. Also, your health benefits must be maintained during any period of unpaid leave under the ame conditions as if you continued to work, and you must be reinstated to the same or an equivalent job with the same ay, benefits, and terms and conditions of employment on your return from leave. If you do not return to work following MLA leave for a reason other than: 1) the continuation, recurrence, or onset of a serious health condition which would ntitle you to FMLA leave; or 2) other circumstances beyond your control, you may be required to reimburse us for our hare of health insurance premiums paid on your behalf during your FMLA leave.

Section 6

Unavailable for signature
*Associate's Signature

Francine Gill
Print Name

1/9/03
Date

Francine Gill
*Department Manager's Signature

Print Name

Date

*HR Manager/Representative Name: Craig Peterson
Please Print

Division 50
Region Number

* *Required*

Check the Applicable Box Below (to be completed by Department Manager):

☒ Recommend Approval of Leave

☐ Do Not Recommend Approval of Leave

Reason: Pending healthcare certification from 1/6/03 to 1/22/03

tion 7 (to be completed by Benefits Department)

☐ Leave of Absence Approved ☐ Leave of Absence Pending ☐ Leave of Absence Denied

NS 1-10-03

efits Reviewer Signature Date

tes: Approved to 1/22 pending medical cert.

H&R BLOCK

Notification of FMLA

TO: Adrian McCrary DATE: 1-10-03

FROM: Natalie Smith PHONE: 816.504.1211

On 1-6-03 (date) you notified us of your need to take family/medical leave due to:

☐ the birth of a child or the placement of a child with you for adoption or foster care; or

☑ a serious health condition that makes you unable to perform the essential functions of your job; or

☐ a serious health condition affecting your ☐ spouse, ☐ child, ☐ parent for which you are needed to provide care.

You notified us that you need this leave beginning on 1-6-03 (date) and that you expect leave to continue until on or about 1-22-03 (date).

An employee is eligible for leave under the FAMILY AND MEDICAL LEAVE ACT (FMLA) if the employee has been employed by the employer for at least twelve months and the employee has been employed for at least 1,250 hours during the immediately preceding twelve month period. An eligible associate who is approved for FMLA based on medical certification may take up to a total of twelve (12) work weeks of unpaid FMLA leave during a twelve (12) month period (or longer if required by applicable state or local law). The twelve (12) month period is determined using a rolling twelve (12) month period measured backward from the date the associate begins using any FMLA leave. Your health benefits must be maintained during any period of unpaid leave under the same conditions as if you continued to work, and you must be reinstated to the same or an equivalent job with the same pay, benefits, and terms and conditions of employment on your return from leave. Leave may be taken on an intermittent or reduced schedule basis if medically necessary.

If you are not eligible for FMLA, you may use accrued paid time off benefits; however, you may or may not be returned to your position depending upon business necessity. Discuss approval of leave and reinstatement with your supervisor and/or your HR Manager/Representative.

FMLA STATUS

This is to inform you that: *(check appropriate boxes; explain where indicated)*

1. This leave has been tentatively identified as leave under FMLA.
2. You are ☑ eligible ☐ not eligible for leave under the FMLA.

☐ N/A A. If approved, the requested leave will be counted against your annual FMLA leave entitlement.

☐ N/A B. You ☐ are ☑ are not a "key employee" as described in §825.218 of the FMLA regulations. If you are a "key employee," restoration to employment may be denied following FMLA leave on the grounds that such restoration will cause substantial and grievous economic injury to us.

PAID/UNPAID TIME OFF

4. At this time, it is estimated that your leave will be:

☑ To Be Determined

☑ paid: PTO
(Note: H&R Block requires that you use accrued paid time concurrently with FMLA)

☐ unpaid: _____
(explanation, if needed)

H&R BLOCK **Notification of FMLA**

For Internal Use Only

Associate Name:	Dre McCray	# 224327
Date Mailed to Associate	1-10-03	
Date Form Returned		
Date Mailed to HR Manager/Rep.	1-10-03	
Due Date of Certification	1-27-03	